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Should lithium be added to the drinking water?

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This month's ANZJP takes a different perspective from the usual clinical and research papers. Jorm (2014) shows that, despite two decades of increasing mental health services, there has been no improvement in the mental health of Australians. This is quite surprising, given the increasing prescription of antidepressants and other psychotropic drugs, the various psychological treatments that are now widely available, and the expansion of state-funded community mental health services. If mental health clinicians were successful in reducing the duration of episodes and achieving recovery for a substantial proportion of patients, then the prevalence of psychiatric disorders should decrease, and this has not occurred. In fact, Jorm (2014) asserts that the only demonstrated success has been in suicide prevention, and this is most likely attributable to a public health campaign rather than to improved treatment of individual patients or improved risk assessment. So, Jorm (2014) proposes that a proportion of the available resources could be more effectively spent on prevention of psychiatric disorders. He acknowledges that sceptical readers may doubt whether this is possible, but goes on to present evidence of successful preventive programs for common conditions such as major depressive disorder.

Extending the public health theme, can we learn from the success of adding fluoride to the drinking water – is there anything similar that can be done in psychiatry? Mauer et al. (2014) demonstrate that, on a population level, the presence of trace lithium in the drinking water is associated with a lower incidence of dementia, along with lower than expected rates of suicide and homicide and reduced mortality. Mauer et al. (2014) also look at long-term, low-dose lithium and demonstrate similar benefits. This is not just a chance association: they describe some of the mechanisms of lithium's neuroprotective actions. The evidence is perhaps not strong enough yet to suggest that we should add low-dose lithium to our morning fish oil, but who knows …

Jorm proposes that there should be a National Strategy for the Prevention of Mental Disorders, saying that this is '*all a matter of political will*'. Who is going to exert this political will and make these preventive strategies a reality? This brings us to the Viewpoint by Allison et al. (2014), which addresses the issue of influencing public health policy. Allison et al. (2014) draw on the CanMEDS framework of competencies, which underpins the Royal Australian & New Zealand College of Psychiatrists (RANZCP) training program. These Fellowship competencies include Health Advocate (RANZCP, 2012), stating that:

> *as Health Advocates, psychiatrists use their expertise and influence to advocate on behalf of individual patients, their families and carers, as well as more broadly, on an epidemiological level. Psychiatrists lessen the impact of mental illness through their understanding of and application of the principles of prevention, promotion and early intervention.*

Whilst many of us advocate for individual patients, advocacy on a more general public policy level has its difficulties, and Allison et al. (2014) highlight some of these. Psychiatrists working in public health systems can be specifically prohibited from joining the public debate, which seems paradoxical given the wealth of knowledge and experience that could be contributed. However, if we take up the proposals of Jorm (2014) and decide that public funding might be better spent, at least in part, on pursuing preventive strategies, then maybe psychiatrists should have a more active role in advocating for this. Continuing the public health theme, Harris et al. (2014) use data from the 2007 National Survey of Mental Health and Wellbeing to examine disparities between service demand and need for treatment.

Premature mortality, predominantly due to cardiovascular disease, in people with serious mental illness, is something else that has not improved over time (Saha et al., 2007). There is far more research about screening and monitoring than intervention, so it's good to see a practical intervention for chronic, seriously unwell patients. Hjorth et al. (2014) describe a Danish study carried out in six long-term social psychiatric facilities for severely

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mentally ill patients. They introduced an intervention to address physical health problems in three of the facilities. The program was not elaborate, predominantly focusing on information sessions for staff about how they might help patients to address various unhealthy behaviours such as smoking and poor dietary choices. Hjorth et al. (2014) used waist circumference as their outcome measure, and found that the control group, but not the intervention group, had a significant increase in waist circumference over the 12 months of the study. The intervention didn't reduce obesity, but did stop it getting worse.

Playwright Richard Foreman (2014) wrote:

> *today, I see within us all … the replacement of complex inner density with a new kind of self-evolving under the pressure of information overload and the technology of the 'instantly available'. A new self that needs to contain less and less of an inner repertory of dense cultural inheritance – as we all become pancake people – spread wide and thin as we connect with that vast network of information.*

Online social networks have also become wide and thin, and King and Delfabbro (2014) discuss the importance of these expanded social media communities (Facebook Families) for adolescents. Internet interactions and 'real-life' people seem interchangeable. Johnston et al. (2014) add to the evidence for internet-delivered CBT, where the input of the live therapist averages 37 minutes per patient. However, perhaps internet-delivered therapies may prove to be a cost-effective way to achieve Jorm's (2014) very worthy goal of reducing the prevalence of psychiatric disorders.

Moving on to more traditional psychiatric research, Chan et al. (2014) take us back in time to dementia praecox, and Brakoulias et al. (2014) describe the role of magical thinking and salience in people who have both obsessive–compulsive disorder and high levels of schizotypy. 'Magic' is how Masson et al. (2014) describe the effects of lithium, and perhaps the addition of lithium to drinking water is the kind of magical thinking needed by politicians to link funding and the needs of our mental health systems.

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